NEW HAMPSHIRE
DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

# New Hampshire's Plan for Supporting Individuals to Live in Home and Community Based Settings

## Implementing the Community Passport Sustainability Plan

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Program Administrator

# History

- Money Follows the Person (MFP): Grant from the Centers for Medicare and Medicaid Services (CMS) that began in 2007
- Community Passport (CPP): New Hampshire's MFP implementation
- Over 300 elders and people with disabilities were assisted to transition from living in institutional settings to community based settings
- Final CPP transitions were completed on March 31, 2016
- Individuals who transitioned continue to be followed for 1 year
- Quality of Life Surveys at the time of discharge and 1 year anniversary

# April, 2016 – June, 2017
# Project Goals and Activities

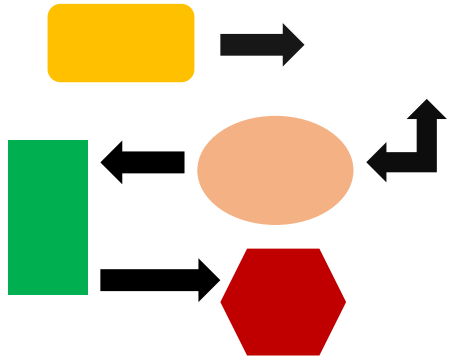
- Continue to support safe, successful community transitions
- Prevent Reinstitutionalization
- Review existing protocols and processes
- Identify gaps and barriers in existing system
- Refine the framework built to support CPP and eliminate gaps and barriers
- Train stakeholders, providers and DHHS staff

# Outreach and Training

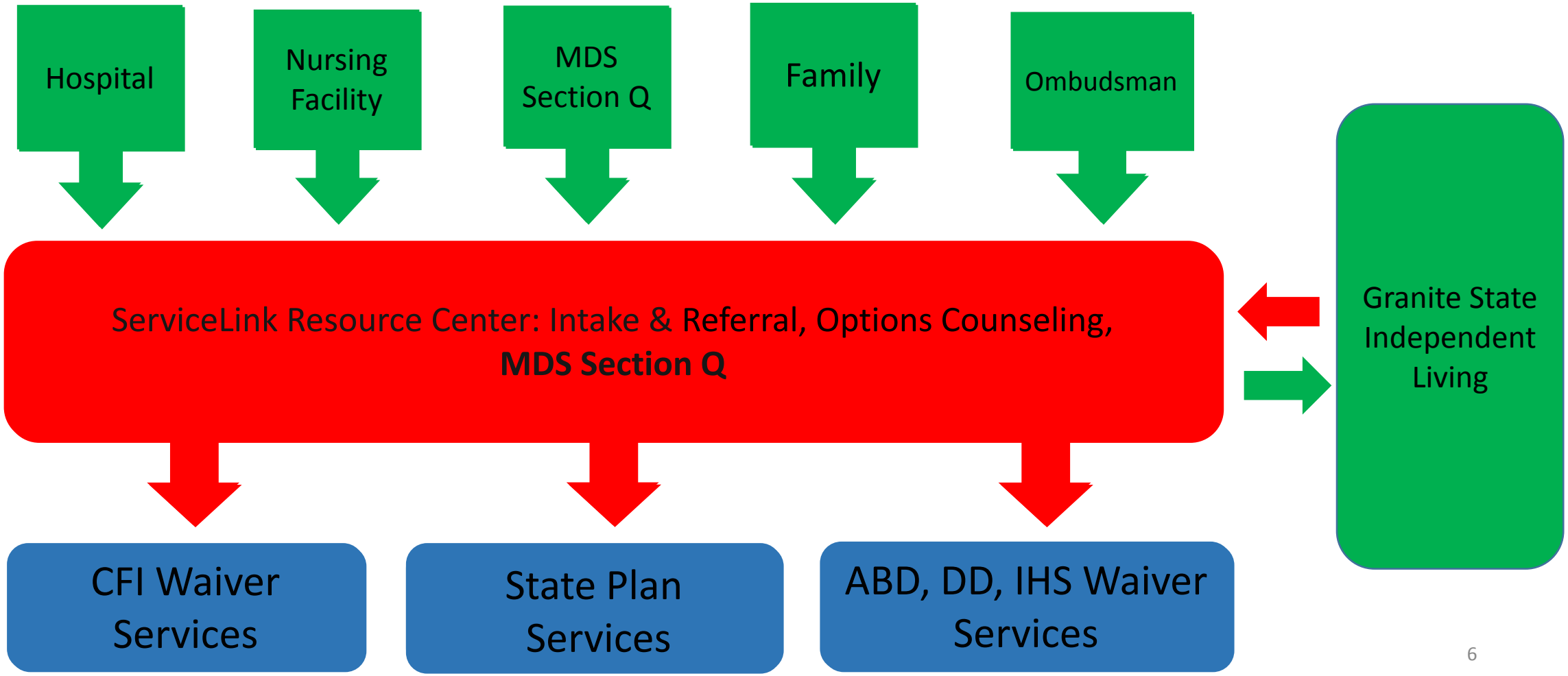
# Agenda

This training will review the **post MFP/CPP processes** that have been put in place to support individuals who express a desire to return to the community based on their response to Section Q of the MDS or other means.

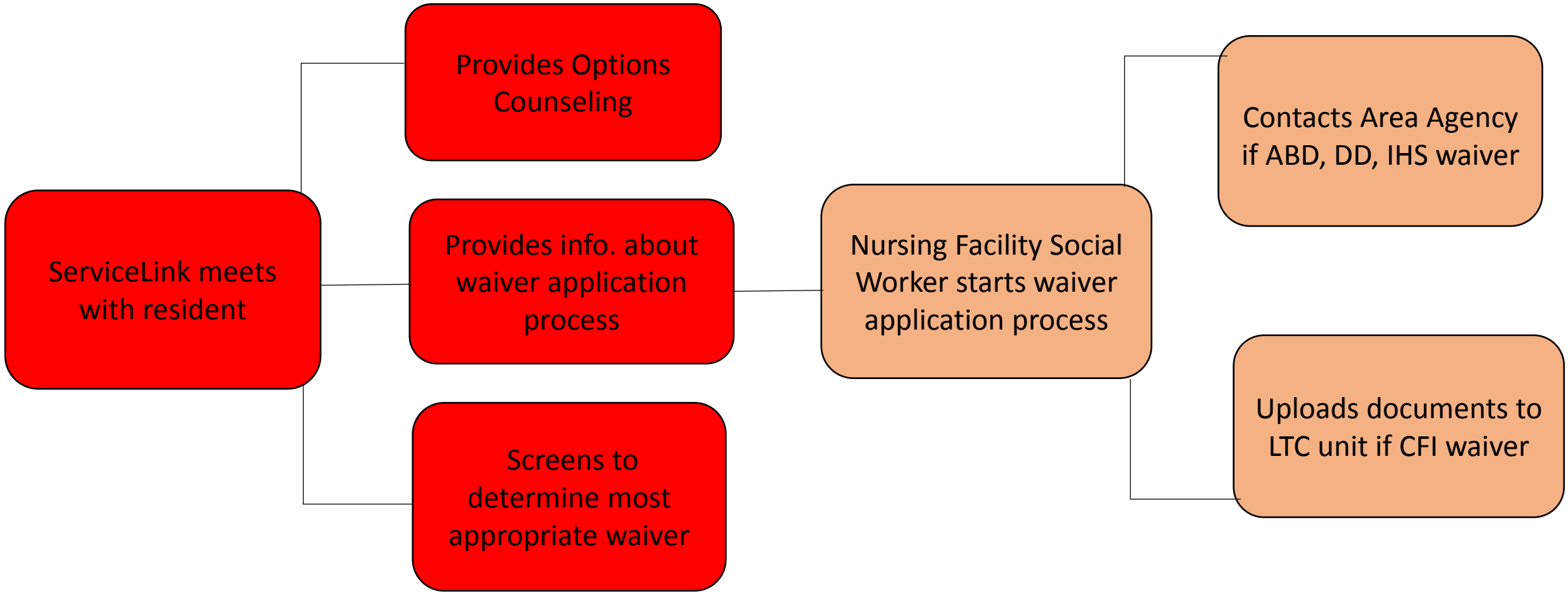
1. Referral
2. HCBS waiver application/eligibility determination
3. Transitional case management and services
4. Service authorizations and claiming



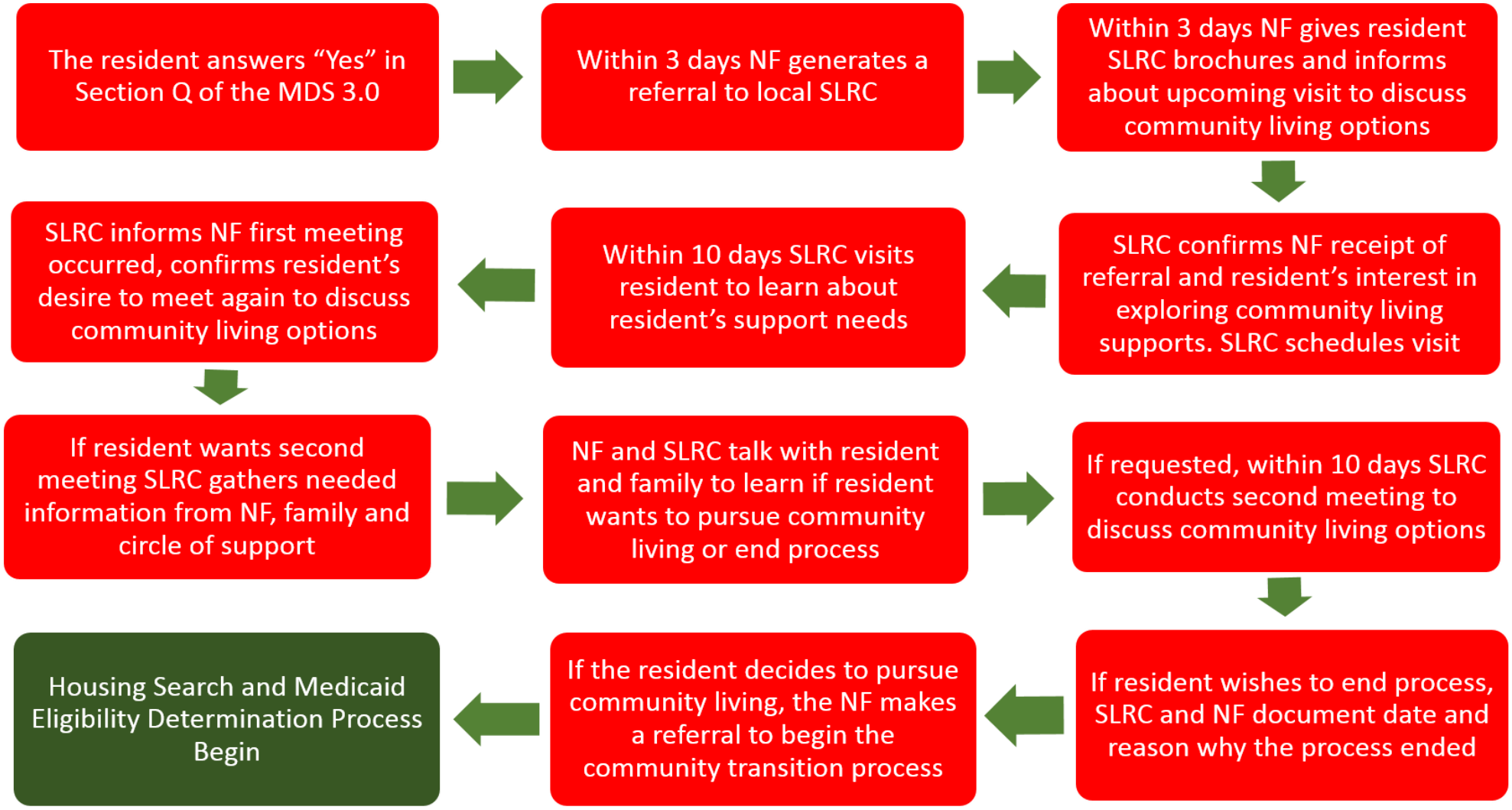
# Referral


Hospital
Nursing Facility
MDS Section Q
Family
Ombudsman
ServiceLink Resource Center: Intake & Referral, Options Counseling, **MDS Section Q**
Granite State Independent Living
CFI Waiver Services
State Plan Services
ABD, DD, IHS Waiver Services

# Referral: ServiceLink



# Referral: MDS Section Q Process



# Referral: GSIL

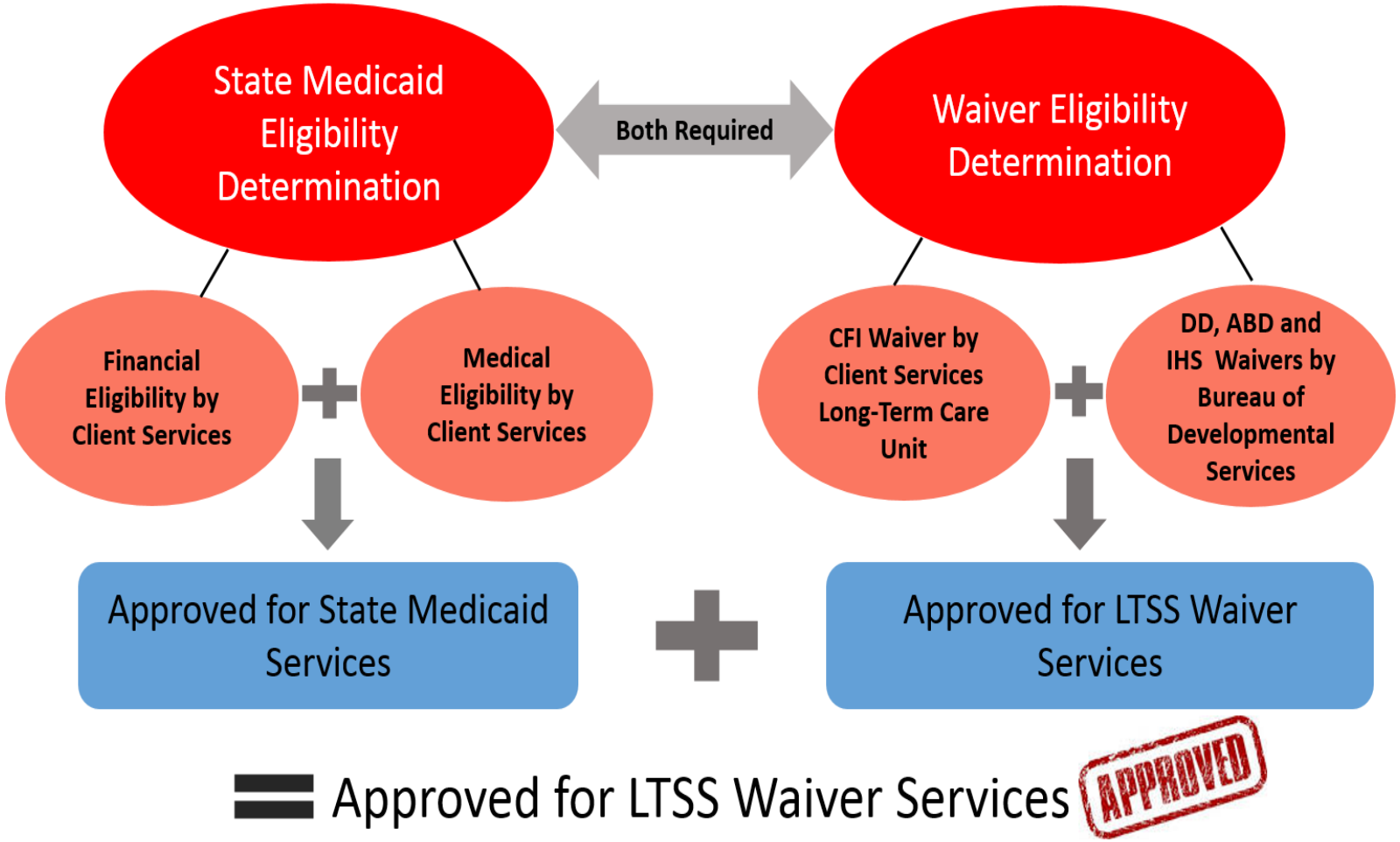
ServiceLink

Granite State Independent Living (GSIL) is a **Center for Independent Living,** which is governed by the US Admin. on Disabilities

GSIL is required to provide five core services:

- Information & Referral
- Individual & Systems Advocacy
- Peer Support & Mentoring
- Independent Living Skills Training
- Transitional Services

# Medicaid Long-Term Services and Supports Eligibility Determination



# Eligibility Determination (CFI)

Facility uploads docs to LTC Unit via NH Easy:

1. Change of Status (COS)
2. PHI release
3. Combined release
4. Completed MEA

(must include clock drawing and medication list)

LTC unit nurse reviews MEA, MEA is scored, eligibility is determined

- Eligibility = NO → LTC unit may request additional information → Individual has the right to appeal decision
- Eligibility = YES → NF, CM and resident are notified and transitional services continue

LTC unit assigns Transitional Case Mgt. (State Plan Service, CM providers may bill prior to CFI approval) → Transitional planning and services begin

**Points to Remember**

- *If MEA was not included LTC unit automatically assigns nurse*
- *The process is triggered when LTC unit receives the COS*

# Transitional Services

## Planning details vary depending on:

- The services and supports needed
- The waiver that services are delivered through
- The system that is supporting the individual

  (Area Agency vs. Independent Case Mgt. provider)

# Transitional Services

## Common elements of planning:

- Communication between Case Manager or Service Coordinator and Nursing Facility to determine the plan and date of discharge
- A Person-Centered approach between the Case Manager or Service Coordinator and the person receiving services to develop a care or service plan
- Requests for authorizations to provide services

# Process Milestones (CFI)

Transitional Services start when the case mgt. agency accepts the case

Case Manager meets with resident and Social Worker to begin the transition process

**Transition Planning:**

- Pre-transition planning meetings with individual, NF social worker, guardian, family members, others
- Risk Assessment
- Housing Assessment

Housing search begins

Housing search and eligibility determination process take place in parallel


Housing timeframe **varies**

**Transitional Services Once Housing has Been Located:**

- Referrals to community services
- Educating the individual about community resources available
- Purchasing furniture, home furnishings and other set-up items
- Securing utilities
- Exploring/securing funding for these elements
- Working with NF social to determine discharge date

# Service Authorizations and Claiming (CFI)

1. At the time TCM agency is assigned, service is authorized for up to 5 units of services in the MMIS system (billing code T1017)

2. CM agency delivers services

3. CM agency enters service delivery info. into the MMIS system

4. CM agency enters claim for services delivered

5. At the time CFI eligibility has been determined the LTC unit enters a preauthorization into Options for Community Transition Service (T2038 HC apt. set-up items/security deposit)

6. Once CFI has been "turned on" CM agency submits copy of receipts to LTC unit for reimbursement of home set-up expenses/security deposit

*Community Transition (T2038 HC) is a CFI billing code for reimbursement of apartment set-up items/security deposit*

*TCM Services is a State Plan service (T1017) billing code*

7. At the time the individual is approved for CFI and a discharge date has been set, the LTC unit assigns Targeted Case Management (T1016), to provide ongoing case management once the transition has taken place

8. CM agency enters service delivery info. into MMIS (no prior authorization is needed)

4. CM agency enters claim for services delivered

Points to Remember

# Glencliff Transitions (not tied to waiver)

- Glencliff staff identifies residents that meet the target population as defined by Community Mental Health Agreement (CMHA) and have a desire to transition into the community
- Glencliff staff identifies providers to coordinate and support transitional and ongoing community living including but not limited to housing, medical and behavioral service access, budgeting, community integration, socialization, public assistance, transportation, education, employment, recreation, independent living skills, legal/advocacy and faith based services

# Glencliff Transitions (not tied to waiver)

- The community provider must be enrolled with Xerox, the Medicaid Managed Care Information System (MMIS) as a Medicaid Provider
- The community provider works with the Glencliff Home to complete their comprehensive assessment and intake and the Department of Health and Human Services (DHHS) Glencliff Transition of Care Community Living Plan. The Individual Service Plan (ISP), the Community Living Plan and Service Authorization (SA) Request along with the budget must also be completed. All documents listed in this procedure must be submitted to the Director at Bureau of Mental Health for approval
- Appendix 1
- Appendix 2

# Glencliff Transitions (not tied to waiver)

- Once the request is approved by the Director of the Bureau of Mental Health, the Service Authorization is forwarded to the Office of Medicaid Services, Medical Services Unit for data entry into the MMIS system
- The Medical Services Unit faxes the Service Authorization number to the community provider for billing purposes and to the Bureau of Mental Health for their file
- The community provider will electronically submit CMS 1500 Form to Xerox for payment

# Glencliff Transitions (not tied to waiver)

## Service Authorizations

- The community provider may request an upfront payment of no more than a quarter of the annual approved budget in order to begin work on the transition
- The annual budget will be authorized in equal quarterly increments. Continued authorization will be tied to concurrent review and progress achieved

# CFI Waiver: MFP/Post MFP Process Comparison

| Area | During MFP | Current Process |
|---|---|---|
| Referral | MDS Section Q referrals were sent to ServiceLink<br>All other referrals sent to CPP Intake Coordinator | All referrals (Section Q and other) are directed to the local ServiceLink |
| Assessments and Options Counseling | Conducted by CPP Coordinator, Housing Specialist and SLRC Options Counselor | Conducted by Transitional Case Manager and ServiceLink Options Counselor. |
| Eligibility determination and coordination | CPP Coordinator worked with NF Social Worker to ensure documents were submitted and LTC unit to coordinate the process | Transitional Case Manager works with NF Social Worker and LTC unit to coordinate process |
| Transitional Case Mgt. (TCM)<br>Transitional Services<br>Community Transition | CPP Transition Coordinator provided or coordinated all services<br><br>CPP staff purchased furniture and other setup items.<br><br>CPP staff setup apartment. | Change of Service (COS) triggers LTC unit to assign TCM based on the individual's request or rotation.<br><br>TCM coordinates/provides all services related to transition. Emphasis is placed on engaging the full array of community resources and natural supports available to support the individual.<br><br>Community Transition services includes (but is not limited to) securing, furnishing and setting up the apt. (limit $1,000 including security deposit). |

# CFI Waiver: MFP/Post MFP Process Comparison

| Area | During MFP | Post MFP |
|---|---|---|
| Service Authorizations<br>Service codes<br>Claiming mechanisms | Third party served as fiscal intermediary.<br><br>Fiscal intermediary provided CPP Transition Coordinator with VISA card for the purchase of apartment setup items.<br><br>CPP Transition Coordinator worked with Green Mountain Furniture (CFI provider) to obtain furniture. | Transitional Case Mgt. Is a State Plan service T1017, which now allows for up to 5 units CM time.<br><br>Community Transition is a CFI service T2038 UCU1 for purchase of 1 time set-up items, security deposit, basic living furnishings, pots and pans, dishes, bedding and cutlery. *Food, rent, room and board costs are NOT covered.*<br><br>CM agency enters service authorization in Options once CFI has been opened. For reimbursement, CM agency submits receipts for items purchased and security deposit. |

# DD, ABD, IHS Waiver: MFP/Post MFP Process Comparison

| Area | During MFP | Current |
|---|---|---|
| Referrals | MDS Section Q referrals were sent to ServiceLink<br>All other referrals sent to CPP Intake Coordinator | All referrals (Section Q and other) are sent to ServiceLink. |
| Assessments and Options Counseling | Community Living Assessment conducted by CPP Coordinator, Housing Assessment by Housing Specialist and Options Counseling by SLRC | Conducted by Area Agency (AA) Intake Coordinator (IC) and ServiceLink Options Counselor (OC). |
| Eligibility determination and coordination | CPP Coordinator supported AA Intake Coordinator as needed | DD, ABD and IHS Waiver referrals are made to one of the 10 Area Agencies for Developmental Services.<br><br>No changes have been made to the following process:<br>AA IC coordinates process with NF Social Worker.<br>Functional assessments are conducted by AA IC to determine support needs and health risks.<br><br>Application file is forwarded to Bureau of Developmental Services (BDS) for review and waiver eligibility decision.<br>Eligibility for the ABD waiver is determined by an ABD review committee, which is made up of brain injury experts and the ABD waiver Administrator. |

# DD, ABD, IHS Waiver: MFP/Post MFP Process Comparison

| Area | During MFP | Current |
|---|---|---|
| Prior to the start of waiver services | When needed, CPP Coordinator worked with AA and Client Services to establish State Medicaid eligibility. | Medicaid and waiver eligibility is established and the individual is placed on a waitlist if applicable |
| Transitional services<br>Service Coordination (case mgt.) | CPP Coordinator worked with AA Service Coordinator (SC) and NF Social Worker on discharge planning and other aspects of community transition.<br>AA SC provided ongoing case mgt. once the individual had transitioned. | AA Service Coordinator (SC) works with NF Social Worker on discharge planning and performs all aspects of community transition.<br>AA SC provides ongoing case mgt. once the individual has transitioned. |
| Individual budgets<br>Payment to service providers | Apartment setup items and furniture are funded by the individual's budget, based on the level of supports required.<br><br>AA accounting department obtains invoices from service providers and enters authorizations for payment. | No changes have been made to the following process:<br><br>AA accounting department obtains invoices from service providers and enters authorizations into Options for payment. |

# Additional Training Available

## Information and Resources:
## Securing Affordable Housing and Community Supports

- Using a Person Centered approach
- The role of housing authorities
- Financial support
  - Section 8 voucher
  - Subsidized housing
  - Other
- The application process
- Working with property managers and landlords
- Supporting the move

- ServiceLink Resource Centers (SLRC) NH's Aging and Disability Resource Centers (ADRC) http://www.servicelink.nh.gov/
- NH CarePath http://www.nhcarepath.dhhs.nh.gov/
- Regional Area Agencies https://www.dhhs.nh.gov/dcbcs/bds/agencies.htm
- Community Mental Health Centers http://www.dhhs.nh.gov/dcbcs/bbh/centers.htm
- NH Department of Health and Human Services (DHHS) https://www.dhhs.nh.gov
- Granite State Independent Living (GSIL), NH's Center for Independent Living https://www.gsil.org/

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

# Abbreviations

AA: Area Agency
ABD: Acquired Brain Disorder
BDS: Bureau of Developmental Services
CFI: Choices for Independence
CMA: Case Management Agency
CM: Case Manager
COS: Change of Service
CPP: Community Passport Program
DCS: Division of Client Services
DD: Developmental Disabilities
DHHS Department of Health and Human Services
IC: Intake Coordinator
LTC : Long Term Care
LTSS: Long Term Services and Supports
MDS: Minimum Data Set
MFP: Money Follows the Person
NF: Nursing Facility
OC: Options Counseling
SC: Service Coordinator
SW: Social Worker
SLRC: ServiceLink Resource Center

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# Questions?

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# Thank You!


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